Form completed by employee requesting catastrophic leave and presents it to HR contact.

REQUEST FORM FOR CATASTROPHIC ILLNESS LEAVE

NAME _____
(Please Print)

SOCIAL SECURITY NUMBER _____

Agency/Office Location _____

Date of Employment with the State of Nebraska _____

Numbers of Hours requested _____ *(attached medical verification must support number of hours requested)*

Reason for Request _____

_____

_____
(attached medical verification must support reason for absence)

MEDICAL VERIFICATION SUPPORTING THIS REQUEST IS ATTACHED

_____ _____
Signature **Date**

Human Resource Use Only:

____Eligible for Catastrophic Leave Donations
Position Number _____

Copy sent to Employee _____ (date)

Info sent to HR contacts _____ (date)
(only if eligible)

____Ineligible for Catastrophic Leave Donations
Reason: _____

_____

Verified by _____ Date _____
Human Resource Contact